MRN

Authorization for Release of Protected Health Information (PHI)

Patient Name | Date of Birth

Address | Telephone Number

I hereby authorize (name of facility/provider releasing information) **to disclose the above-named individuals health information:**

Name (facility releasing information) Address City State Zip

Telephone Number

Date(s) of Service Requested (if known) or Provider: ______________________

Description of Information to be released: (check all that apply)

___Progress notes
___Consultations
___Most recent history and physical
___Immunization record
___Other______________________
___Laboratory reports
___Radiology/Imaging reports
___Radiology films
___Two-way verbal exchange of communication
___ Entire medical record

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization (receiving the information)

Name (facility receiving information) Address City State Zip

Telephone Number

Description of the purpose of the use and/or disclosure: (check one)

___Continuing Care
___Consultation
___Legal purposes
___Second Opinion
___Insurance
___Personal Use
___Emergency/acute care
___Social Security/Disability (provide copy of SSA Letter)
___Other: Please describe: ______________________
___Marketing-If this request is for marketing purposes, ADC may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's protected health information (PHI).

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. The Austin Diagnostic Clinic may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until ______________________ (date or event).

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at The Austin Diagnostic Clinic. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

______________________ ______________________

Signature of Patient or Patient's Representative **Date**

____

Printed name of Patient or Patient's Representative

______________________ ______________________

Relationship to Patient or **Legal Authority (attach supporting documentation)**